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HEALTH SOLUTIONS

Aging Well: Addressing Behavioral Health with Older Adults in Primary Care Settings

February 15, 2017

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Moderator:

Roara Michael, Associate, CIHS

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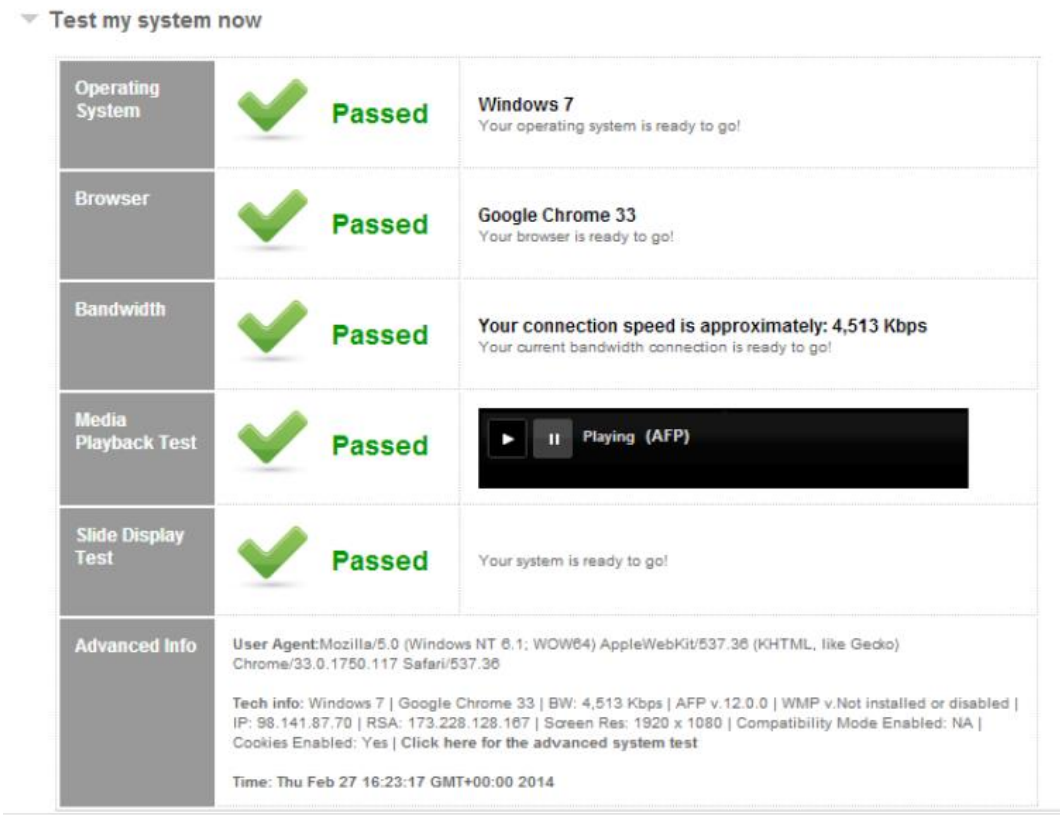

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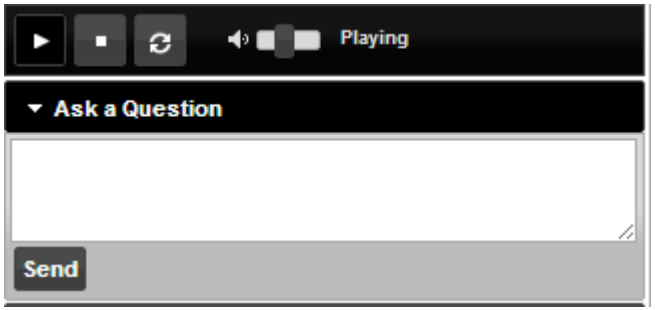
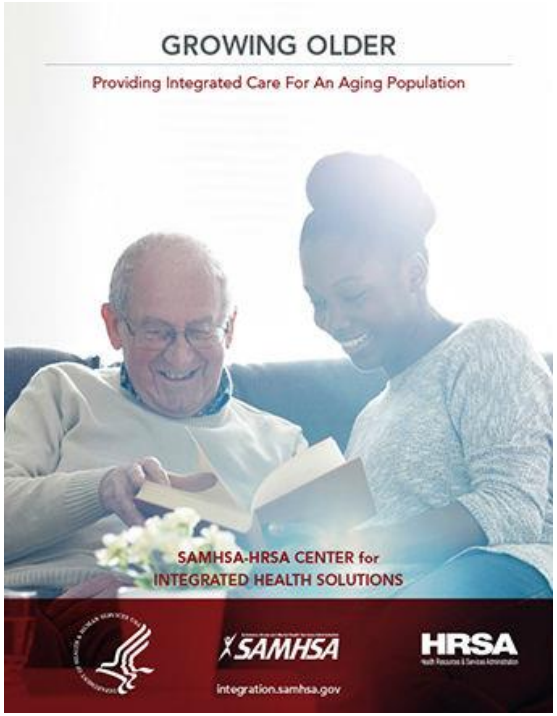


Older Adults Issue Brief



Link to download:

http://store.samhsa.gov/shin/content//SMA16-4982/SMA16-4982.pdf

Learning Objectives

- Understand the complex array of health, behavioral and social issues that should be addressed during clinical encounters with older adults
- Distinguish the differences between common mental health, substance use and physical health conditions
- Recognize the steps to develop an integrated behavioral health and primary care workforce that is ready to serve an aging population
- Identify evidence-based practices and other resources for serving older adults in an integrated manner

Today's Speakers

Amanda Pettit, RN, MSN

Clinical Nurse Manager, Crossing Rivers Health Primary Care Clinic, Behavioral Health Clinic and Center for Specialty Care Clinics

Ashley Hady, MSW, LCSW

Licensed Clinical Social Worker, Crossing Rivers Health

Stephen Bartels, MD, MS

Herman O. West Professor of Geriatrics

Professor of Psychiatry, Community and Family Medicine, and The Dartmouth Institute Geisel School of Medicine at Dartmouth

Director, Dartmouth Centers for Health and Aging

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Identifying Mental Health Needs in Older Adults in Rural America

From the World of Primary Care in Collaboration with Behavioral Health via Telehealth

Ashley Hady MSW, LCSW
Mandy Pettit RN, MSN
Crossing Rivers Health

Who We Are….Crossing Rivers Health

- Independent primary and behavioral health clinics
- Under the “umbrella” of a CAH- CRHMC
- Number of patients ≥ 65yrs old seen since 2014:
  - 901(Includes primary and behavioral health)
- Profile of Services
  - Primary Care from prenatal to death:
    - Wellness, preventive, med management
  - Behavioral Health from adolescence to geriatrics:
    - Counseling
    - Medication management
    - Diagnostic evaluation
    - Screening and referral

Who We Are….Crossing Rivers Health

- Our workforce- Primary Care and Behavioral Health:
  - 2 Board Certified Family Medicine Doctors
  - 1 Board Certified Internal Medicine Doctor
  - 2 Board Certified Family Nurse Practitioners
  - 1 Board Certified Family Nurse Practitioner and Certified Nurse Midwife
  - 1 Licensed Clinical Social Worker
  - 1 Psychiatrist
  - 1 RN- Telehealth Facilitator/Care Coordinator

What Our Data Shows….

Specific to patients ≥65yrs diagnosed with depression and/or anxiety. (ICD code 296 & 300)

- 126 diagnosed in Primary Care Clinic
- 5 patients are currently being seen by a counselor or a psychiatric prescriber. Only 3.9%
- 2 Referrals were sent by primary care but refused by patient.

What Primary Care Providers hear…

Patient perception	• “I’ve lived through worse than this…” • “I trust you, can’t you just take care of it?”
Transportation	• Do not or cannot drive anymore • Who is going to take me to another appointment?
Cost	• Fixed incomes • Does insurance cover visits with prescriber? Counselor? • Does insurance cover prescriptions

What Primary Care Providers Say…

- “I already know the patient, I’ll just take care of it.”
- “It’s not personal if it’s through telehealth, my patients won’t like that.”
- “I can’t make them go.”
- “The patient hardly comes in to see me, how are we supposed to get them to see a psychiatrist or counselor?”
- “This patient doesn’t need another medication, more side effects, etc.”

What Primary Care Providers Do…

- **Continue to routinely screen patients with:**
  - PHQ-2 (at Medicare Wellness Exams)
  - PHQ-9
  - GAD-7

- **Determine when to introduce different treatment modalities.**
  - "Watchful waiting"
  - Medications
  - Therapy
  - HOW is this DECIDED?....Different for every provider and his/her relationship with patient……

Integration of Care… Utilizing Evidence-Based Model: "Telemedicine-Based Collaborative Care"

Primary Care Clinic

- Part of the "TEAM" which allow for more continuity of care
- Empowers patients and caregivers to make decisions about treatment options…i.e. counseling, medication management etc.

Behavioral Health Nurse/Care Coordinator

- Communication "back to" Primary Care when patient is seen
- Communication with long-term care model
- APS-Adult Protective Services

Integration of Care… Utilizing Evidence-Based Model: “Telemedicine-Based Collaborative Care”

Counseling-LCSW, LPC

- Individualized comprehensive mental health assessment
- Strength-based assessment
- Patient-centered treatment planning

Community Resource Director

- Grant development- HRSA Mental Health Through Tele-medicine
- Service development initiatives
- Crossing Rivers Telehealth Consortium Project Director

How can WE effect CHANGE…

EDUCATE

- Providers
  - Patient flow, hand-offs
  - Provide feedback from patient surveys
- Patients
  - BH whether face-to-face or telehealth, it isn't so "different"

COLLABORATE

- Connecting BH providers with Primary Care consistently
- Community Resources
  - APS
  - Long-term Care Model

How can WE effect CHANGE (cont'd)…

LOCATION of SERVICES

- Current-state- House a few blocks across town
- Future-state- On-site with Primary Care

Our Vision for the future…

- Continue to refine the Evidence-Based Model
- Increase access to care
- Maintain provider continuity
- Sustain services
- Decrease negative stigmatism
- Integrate behavioral health as part of OVERALL health management
- Keep the conversation going….

QUESTIONS?

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  - Clinic Nurse Manager
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Questions ?

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Aging Well: Addressing Behavioral Health with Older Adults in Primary Care Settings

Steve Bartels MD, MS

Herman O. West Professor of Geriatrics

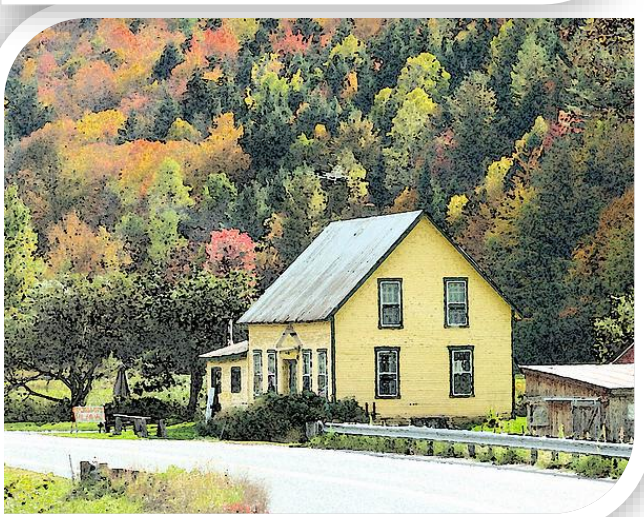
Professor of Psychiatry, Community and Family Medicine,
and The Dartmouth Institute

Geisel School of Medicine at Dartmouth

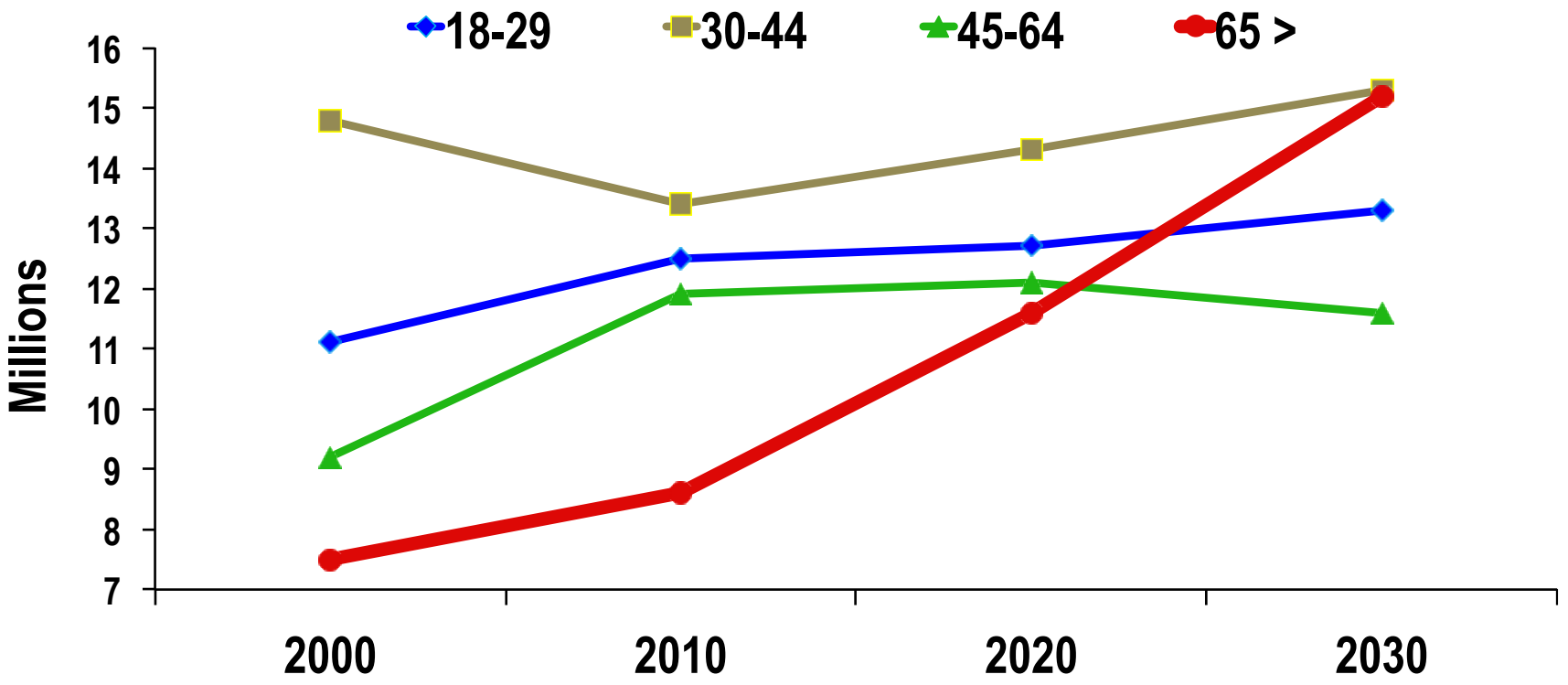
Director, Dartmouth Centers for Health and Aging

Overview

- Behavioral Health as a Health Care Problem for Older Adults
- Evidence-base Practices
- Models of Care
  - Integration in Primary Care
  - Health Coaching & Self Management
  - Technology
  - “Reverse Innovation”
  - Community Outreach & Support for Aging in Place



11 Million Older Americans with Mental Illness Today- 15 million in 2030



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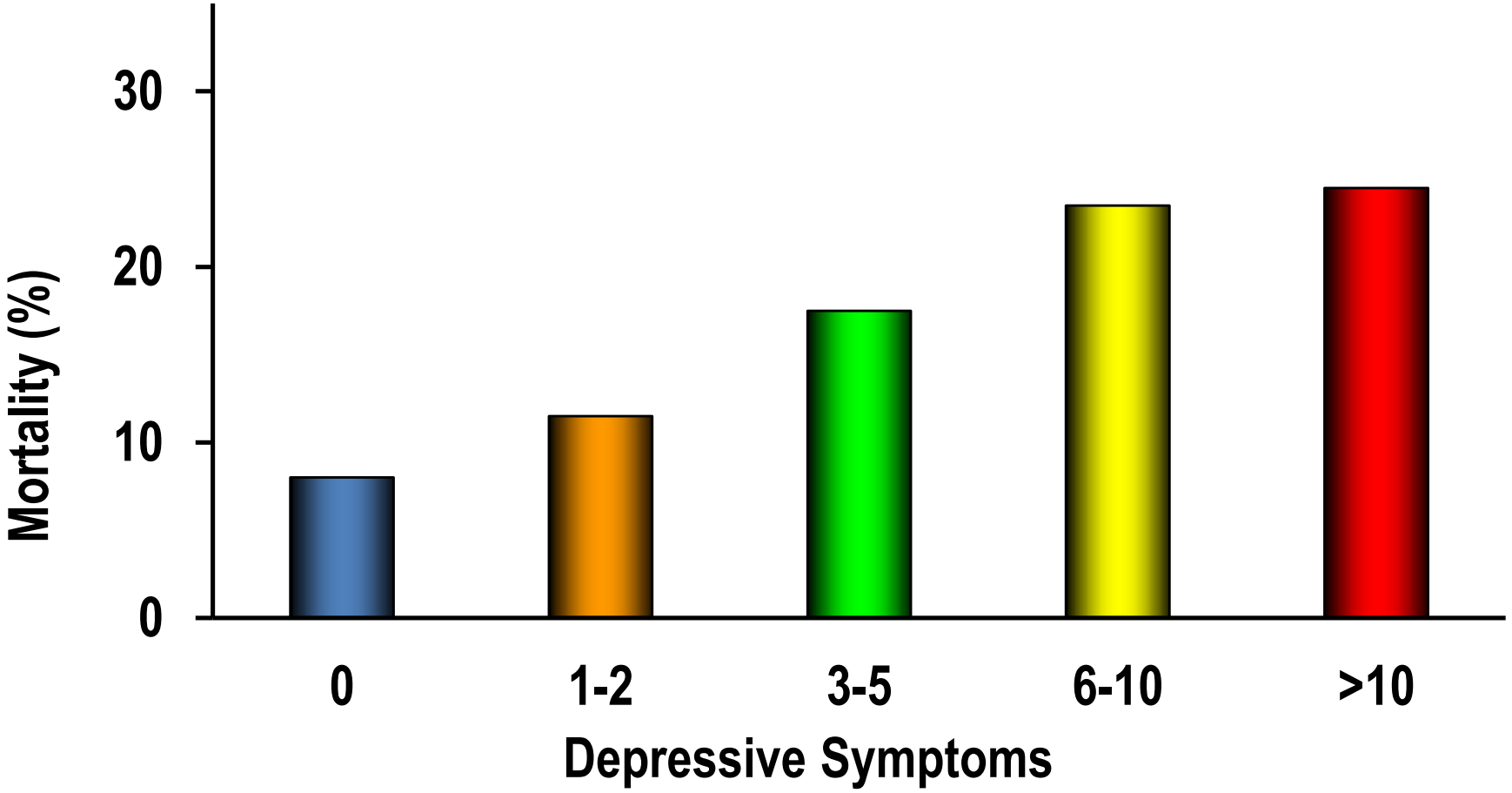
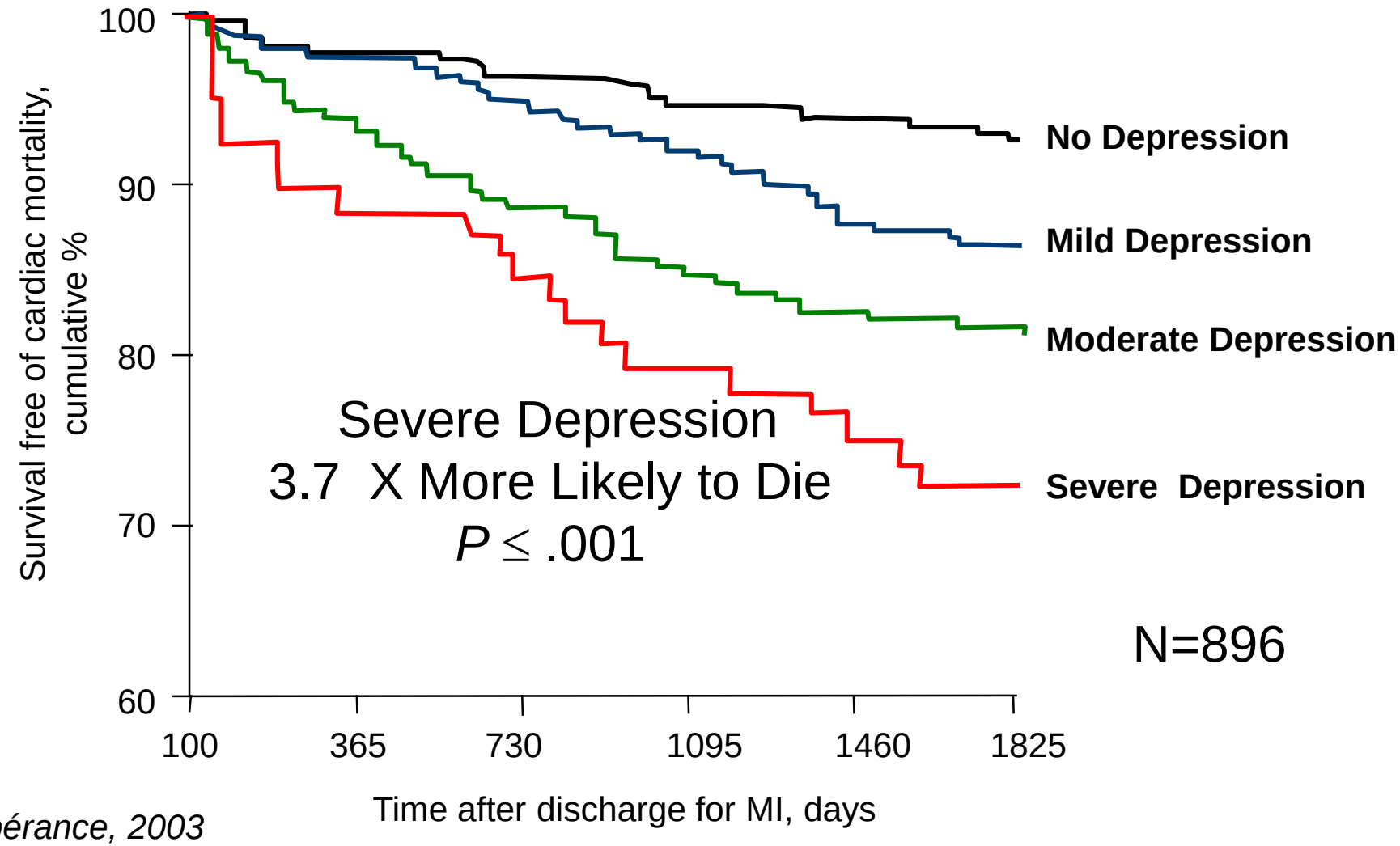
Behavioral Health in Older Adults is a Health Care Problem

Depression Kills Older Women 7 Years After Hip Fracture

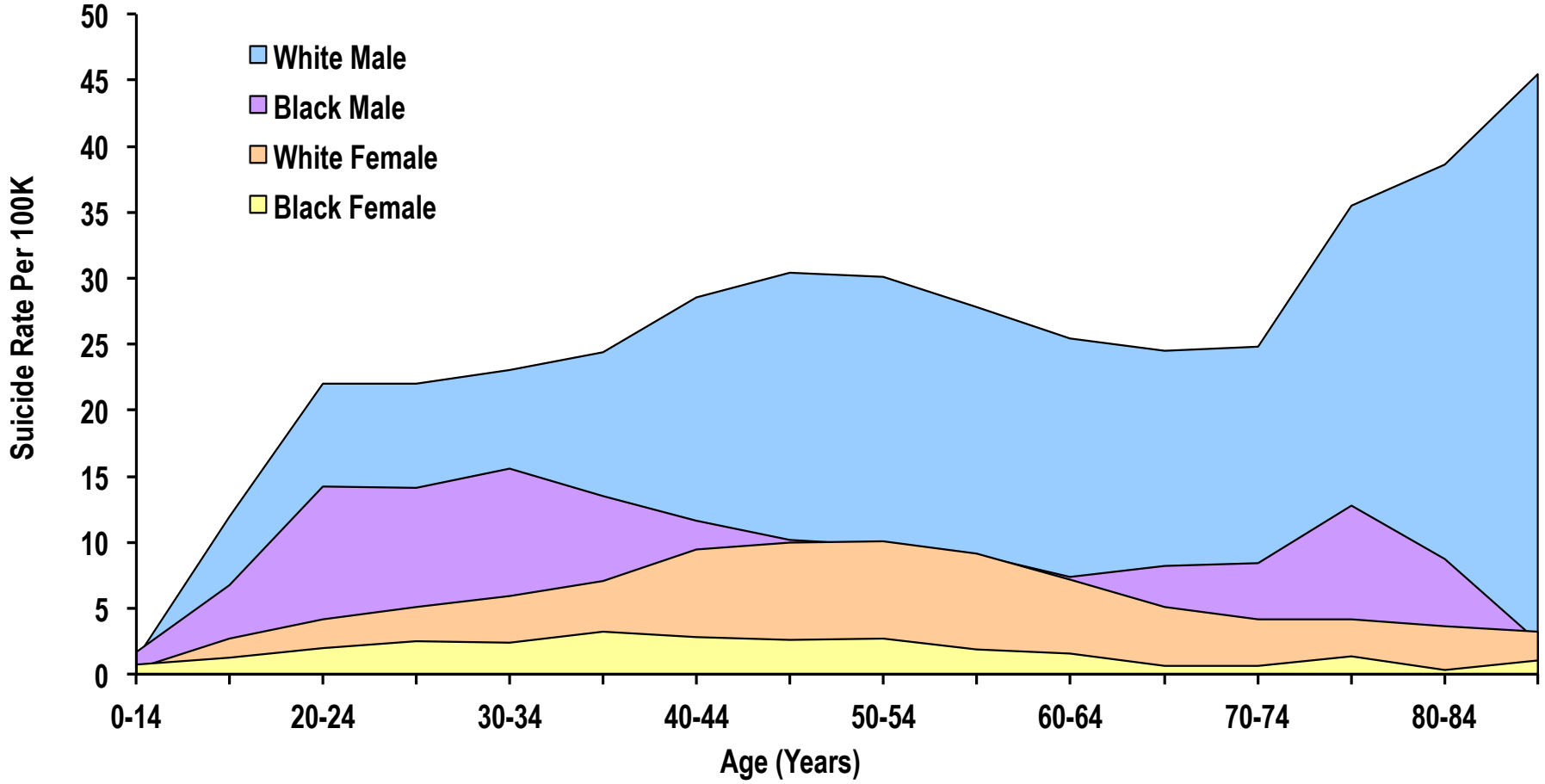


Depression and Greater Likelihood of Mortality After Heart Attack

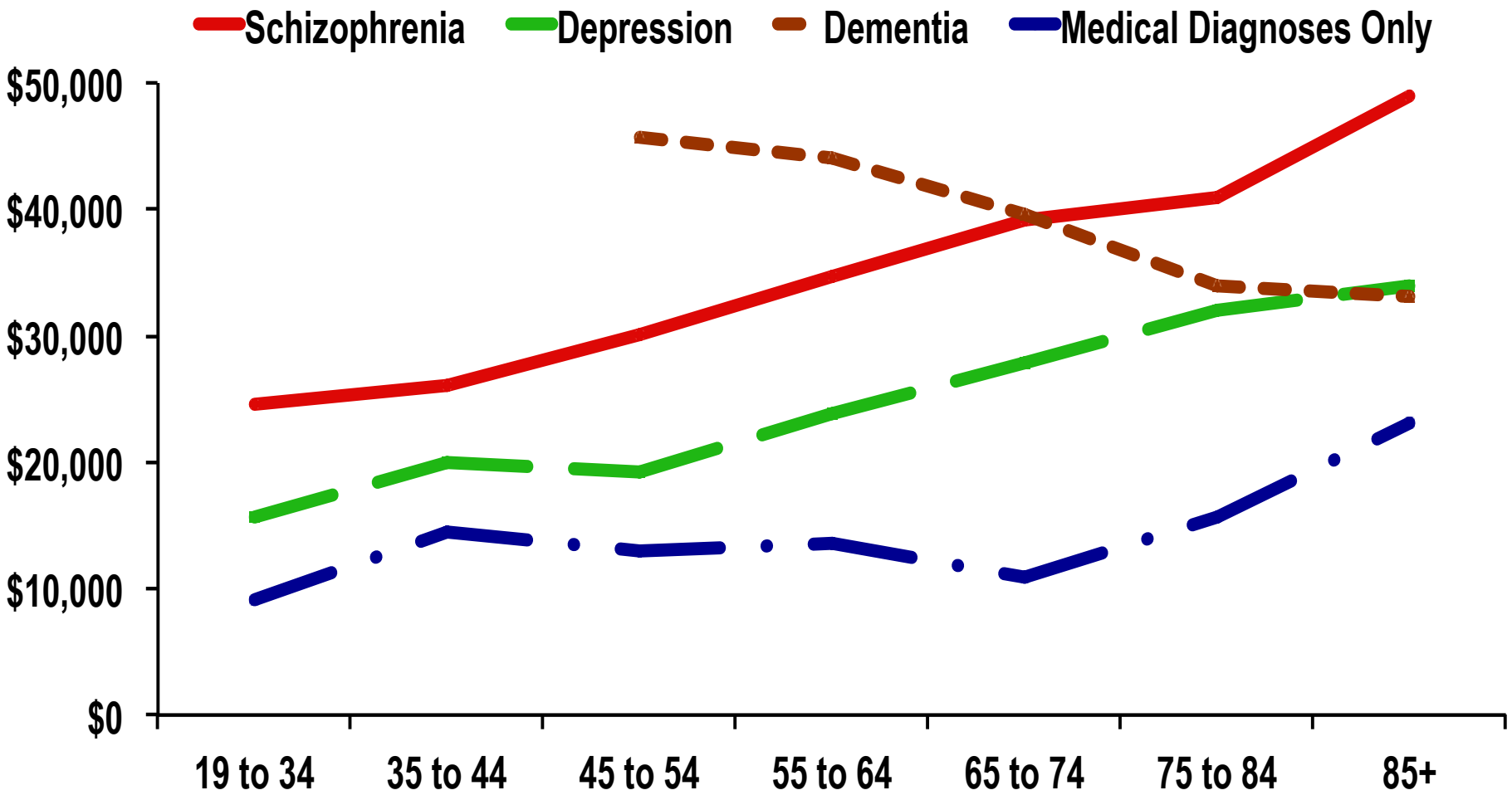


Lespérance, 2003

Depression Kills Older Men



Mental Illness Can Double or Triple Costs Across the Lifespan



"We Know Treatment Works" Evidence-based Practices

- Integrated service delivery in primary care
- Mental health outreach services
- Mental health consultation and treatment teams in long-term care
- Family/caregiver support interventions
- Psychological and pharmacological treatments

Bartels et al., 2002, 2003, 2005

Integrated Collaborative Care

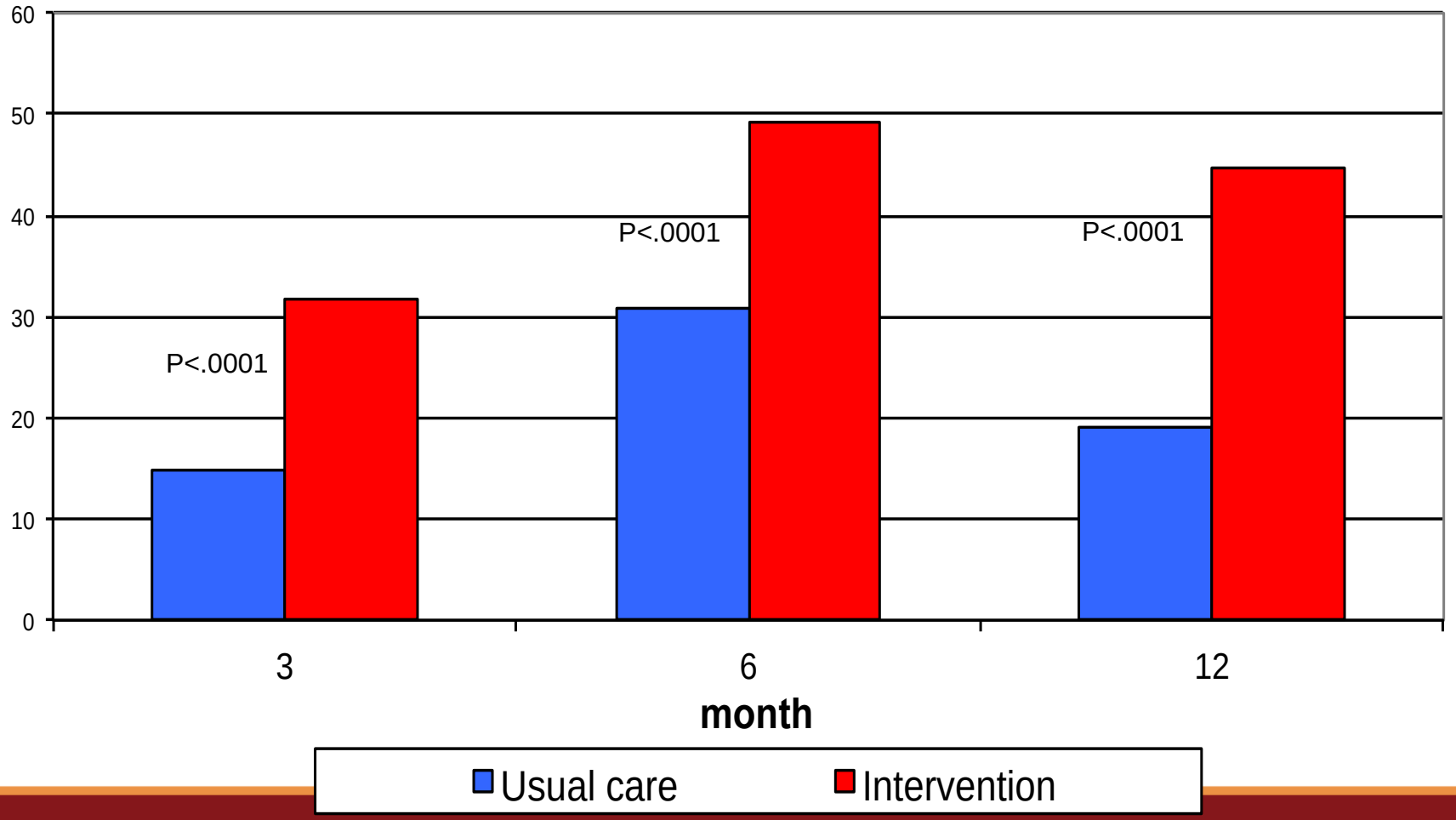
Collaborative care model includes:

- **Care manager: Depression Clinical Specialist**
  - **Patient education**
  - **Symptom and Side effect tracking**
  - **Brief, structured psychotherapy: PST-PC**
- **Consultation / weekly supervision** meetings with
  - **Primary care physician**
  - **Team psychiatrist**

Stepped protocol in primary care using antidepressant medications and / or 6-8 sessions of psychotherapy (PST-PC)

Unützer et al, JAMA 2002; 288:2836-2845

Clinically Significant Improvement in Depression (≥50% Drop on SCL-20 Depression Score from Baseline)



Unützer et al, JAMA 2002; 288:2836-2845.

Integrated Care is More Cost Effective Than Usual Care

IMPACT participants had lower mean total healthcare costs $29,422 compared to usual care patients $32, 785 over 4 years.

MANAGERIAL

Long-term Cost Effects of Collaborative Care for Late-life Depression

Jürgen Unützer, MD, MPH; Wayne J. Katon, MD; Ming-Yu Fan, PhD; Michael C. Schoenbaum, PhD; Elizabeth H. B. Lin, MD, MPH; Richard D. Della Penna, MD; and Diane Powers, MA

Objective: To determine the long-term effects on total healthcare costs of the Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) program for late-life depression compared with usual care.

Study Design: Randomized controlled trial with enrollment from July 1999 through August 2001. The IMPACT trial, conducted in primary care practices in 8 delivery organizations across the United States, enrolled 1801 depressed primary care patients 60 years or older. Data are from the 2 IMPACT sites for which 4-year cost data were available. Trial enrollment across these 2 health maintenance organizations was 551 patients.

Methods: Participants were randomly assigned to the IMPACT intervention (n = 279) or to usual primary care (n = 272). Intervention patients had access to a depression care manager who provided education, behavioral activation, support of antidepressant medication management prescribed by their regular primary care provider, and problem-solving treatment in primary care for up to 12 months. Care managers were supervised by a psychiatrist and a primary care provider. The main outcome measures were healthcare costs during 4 years.

Results: IMPACT participants had lower mean total healthcare costs ($29 422; 95% confidence interval, $26 479-$32 365) than usual care patients ($32 785; 95% confidence interval, $27 648-$37 921) during 4 years. Results of a bootstrap analysis suggested an 87% probability that the IMPACT program was associated with lower healthcare costs than usual care.

Conclusion: Compared with usual primary care, the IMPACT program is associated with a high probability of lower total healthcare costs during a 4-year period.

(Am J Manag Care. 2008;14:95-100)

Major depression and dysthymic disorder (chronic depression) are common in older adults. In addition to causing impairment of functioning and quality of life, depression in late life has been associated with substantial increases in total healthcare costs.[1,2] The Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) trial[3] enrolled 1801 depressed older primary care patients from 8 healthcare systems in a randomized controlled trial of a collaborative care management program for depression compared with care as usual. Participants from each organization were randomly assigned to collaborative care or to care as usual.

Earlier findings from the IMPACT study[3] reported that the collaborative care program was substantially more effective than care as usual in reducing depression and in improving physical and social function. Intervention patients continued to have significantly less depression than patients in usual care even at the 24-month follow-up, 12 months after the end of the intervention program.[4] Analyses from the IMPACT trial[5] found the collaborative care program to be substantially more cost-effective than care as usual. IMPACT participants experienced 107 more depression-free days during a 24-month period than patients assigned to care as usual. During the initial study year, total healthcare costs (including the costs of the IMPACT intervention) were slightly higher among the intervention group than among control subjects, but a slight decrease in costs among the intervention group compared with usual care patients was observed in the second year, suggesting that an initial investment in better depression care may result in long-term cost savings.[5]

In this article, we report long-term (4-year) effects of collaborative care for late-life depression on total healthcare costs from a payer's perspective. Our findings are based on cost data available from 2 participating group-model health maintenance organizations.

METHODS

Trial

Detailed information about the methodology, clinical results, and 2-year cost-effectiveness outcomes from the IMPACT trial are reported elsewhere.[3,5-7] The institutional review boards of all participating organizations and the study coordinating center approved all study procedures, and all patients provided written informed

In this issue
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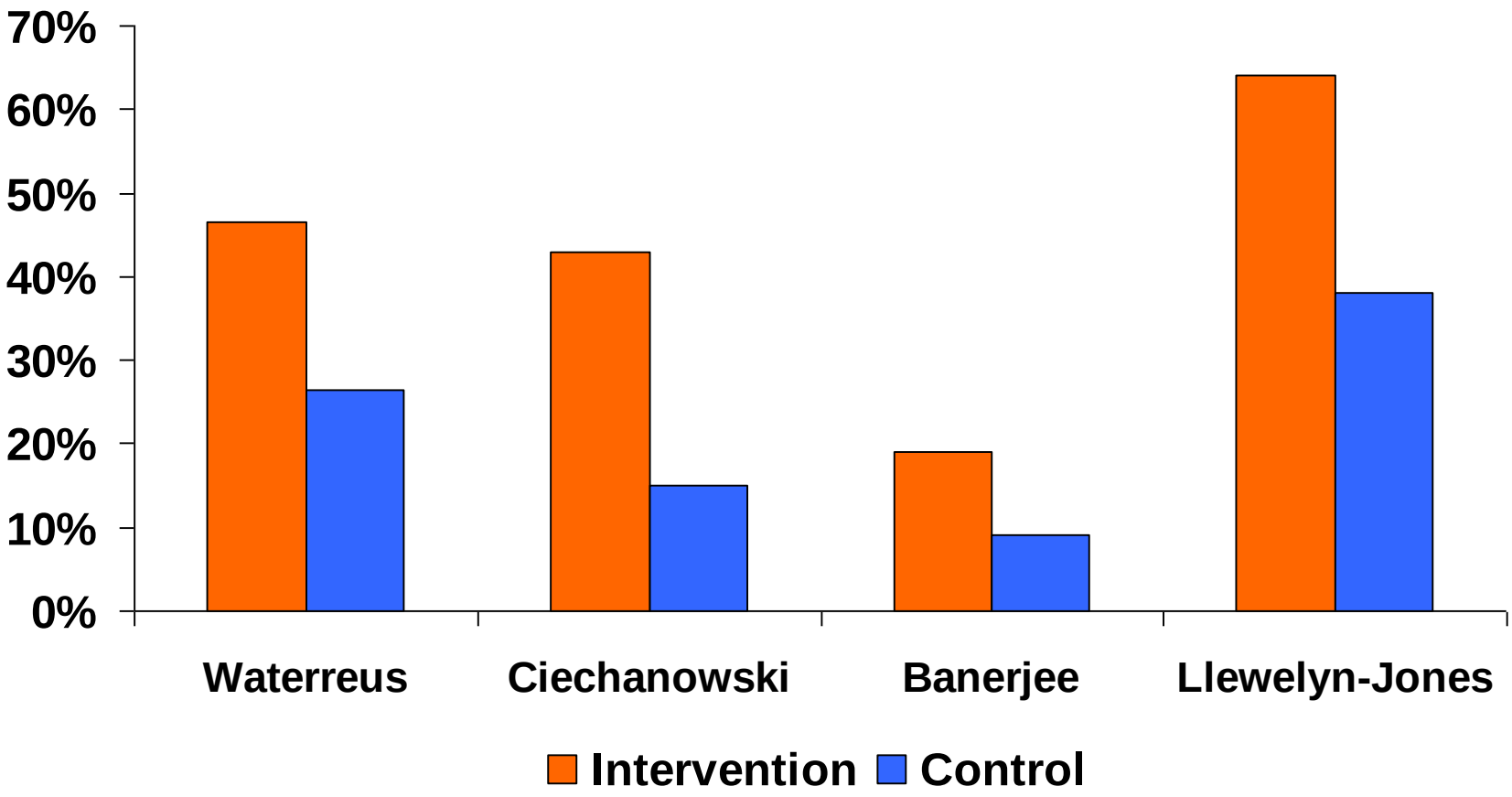
For author information and disclosures, see end of text.

RCTs of Geriatric Mental Health Community Outreach Models % Recovered from Depression*



* Greater than 50% reduction in symptoms or meeting syndromal criteria

Prevention Works!

Preventing Late-life Depression in Age-Related Macular Degeneration

Barry W. Rovner, M.D., Robin J. Casten, Ph.D.

Objective: *To determine whether problem-solving treatment (PST) can prevent depressive disorders in patients with age-related macular degeneration (AMD).* **Design:** *Two hundred six patients with AMD were randomly assigned to PST (n = 105) or usual care (n = 101). PST therapists delivered six PST sessions over 8 weeks in subjects' homes.* **Measurements:** *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition Diagnoses of Depressive Disorders, Hamilton Depression Rating Scale scores, and rates of relinquishing valued activities were assessed at 2 months for short-term effects and 6 months for maintenance effects.* **Results:** *The 2-month incidence rate of depressive disorders in PST-treated subjects was significantly lower than controls (11.6% versus 23.2%, respectively; OR = 0.43; 95% CI [0.20, 0.95]). PST also reduced the odds of relinquishing a valued activity (OR = 0.48; 95% CI [0.25, 0.96]); this effect mediated the relationship between treatment group and depression. By 6 months most earlier observed benefits had diminished. Secondary analyses showed that a minimal level of depressive symptoms were disabling and predicted incident depressive disorders.* **Conclusion:** *PST prevented depressive disorders and loss of valued activities as a short-term treatment but these benefits were not maintained over time. To sustain PST's effect, an intervention that uses a problem-solving framework to enhance rehabilitative skills may be necessary.* (Am J Geriatr Psychiatry 2008; 16:454–459)

Key Words: Problem-solving treatment, vision loss, age-related macular degeneration, depression

Preventing depression in older people might seem improbable given the medical problems, disability, and social losses that many experience and the view that depression is an inevitable consequence of aging. Although most older persons will never, in fact, become depressed, many have medical problems and physical disabilities or stressful life events, chronic life difficulties, or poor coping skills that increase their risk. Developing targeted early interventions for these persons may prevent them from becoming depressed.

We have focused on preventing depression in persons with vision loss due to age-related macular degeneration (AMD). AMD is the leading cause of severe vision loss in older adults, with almost two million having advanced disease (neovascular or

Received October 8, 2007; revised January 10, 2008; accepted January 14, 2008. From the Departments of Psychiatry and Neurology (BWR), and Psychiatry and Human Behavior (RJC), Jefferson Medical College, Jefferson Medical College, Philadelphia, PA. Send correspondence and reprint requests to Barry W. Rovner, M.D., Jefferson Hospital for Neuroscience, 900 Walnut Street, 4th Floor, Philadelphia 19107, PA. e-mail: barry.rovner@jefferson.edu

EDITORIAL

Preventing Depression in Old Age: It's Time

Charles F. Reynolds III, M.D.

Although depression in old age can be successfully treated, often to response if not full remission of symptoms, persisting impairment in functional status and in health-related quality of life is all too common.[1] Long-term treatments also work to reduce rates of recurrence of major depressive episodes by about 50%;[2] however, maintenance of quality of life is far from satisfactory.[2] Thus, the illness-related burden of depressive illnesses, particularly in old age, continues to be an important public health challenge and looms larger still because of the increasing numbers of elderly people in developed economies.

Moreover, elderly who are members of minority groups are even less likely to access and engage in effective treatment of depression.[3] Thus, it is not surprising that African Americans, for example, are overrepresented among those with severe depression.[4] If you are old, depressed, and African American or Latino, you have three strikes against you.

We know now that evidence-based treatments for depression in old age can and do work in primary care settings;[5,6] however, the diffusion of models of depression care management to the general medical sector has to date been limited, often for financial reasons. Two-minute mental health visits are the rule, limiting the access of patients to adequate treatment and guaranteeing suboptimal outcomes.[3]

This state of affairs underscores the need to prevent old-age depression. That is, if the efficacy of treatment, while good, is still limited with respect to reversing illness related burden; and if diffusability of evidence-based practices to general medicine is limited, particularly in minority populations; then the need to prevent old age depression in the first place is of great public health moment. I suggest that our field needs to make a commitment to depression prevention research, and that scientifically the time has come.

Smit et al.[7,8] have done the basic epidemiology to identify characteristics that put elderly people at high risk, both for incident[7] and persistent[8] depression. In their work, having symptoms of anxiety, functional impairments, two or more chronic illnesses and either low education or below average levels of mastery identify elderly persons at high risk for persistent depression. The authors have taught us that profiles of high risk characterize relatively small segments of the elderly population; and that if one could contain the adverse effects associated with such risk factors, then the incidence of persisting depression could be substantially reduced (i.e., high attributable fraction). Also, reasonable efficiency is possible, assuming acceptable and effective interventions (as indexed by a number needed to treat of approximately 3).

What type of preventive intervention could make the most sense scientifically and be acceptable to patients at high risk? The review by Cole[9] reminds us that brief psychosocial interventions, especially those that are learning-based, are acceptable and feasible, as evidenced by good enrollment and completion rates. Furthermore, based upon the available studies, reductions in absolute and relative risk for incident depression appear to be promising and thus justify the effort of mounting further prevention research in high-risk older people. What is meant by high risk?

Rovner et al.[10,11] have done ground-breaking research into selective prevention of depression in older adults, that is, taking a group of people at high risk, by virtue of known risk factors (e.g., bereavement, insomnia, limited social support) but not yet

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SBIRT MODEL for Misuse of Alcohol and Psychoactive Prescription Medications

- Screening
- Brief Intervention
- Referral to Treatment

Trials with Older Adults:

êBrief Interventions (BI) can reduce use and some problems for at least 12 months among younger and older adults

ê(Ex: Reductions in drinking of 40%)

Implementation in 'real world settings'

•American Society on Aging (ASA), 2005 (Blow, Barry)

•Schonfeld, et al, 2010 (Florida BRITE Project)

AOA-SAMHSA Issue Briefs

OLDER AMERICANS BEHAVIORAL HEALTH
Issue Brief 1: Aging and Behavioral Health Partnerships in the Changing Health Care Environment

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults.

This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA is providing technical expertise and tools, particularly in the areas of suicide, anxiety, depression, alcohol and prescription drug use and misuse among older adults, and partnering with AoA to get these resources into the hands of aging and behavioral health professionals.

State Aging and Behavioral Health Partnerships

States are advancing older adult behavioral health services through partnerships between State Aging, Mental Health, and Single State Authorities. These partnerships have increased access to health interventions for suicide prevention, depression, at-risk alcohol and medication misuse, and chronic disease management such as the evidence-based practices and programs identified in this Brief. Access has improved for adults with mental health and substance use disorders and for those who are at-risk for developing these disorders. Successful partnerships can link aging and behavioral health providers in the community.

Behavioral health agencies and aging service providers that partner can offer health interventions as well as link older adults to specialists who address high-risk medication and alcohol use, depression, anxiety, and suicide prevention. Primary care providers can benefit by participating in these partnerships and referring older adults to appropriate evidence-based prevention, screening, and brief intervention practices.

- Many aging service providers offer care management, chronic disease self-management, and other evidence-based health promotion and prevention programs. Aging service providers also link older adults with benefits information and long-term services and supports. Health systems that choose to partner with aging service providers and behavioral health providers can better reach dual eligible and home-bound populations and link to community-delivered evidence-based services, to ultimately improve care coordination and reduce cost.

Key components of effective aging and behavioral health partnerships that result in positive health impacts for older adults and improved service delivery systems include:

- **Leadership** of at least one state government champion who has a goal of increasing or improving access to health services, building systems of delivery, mobilizing partners, taking advantage of opportunities, and proactively developing strategies to capitalize on new opportunities.
- **Advocacy** resulting in financing, policy, or program change that increases or improves access to health services.
- **Directed funding** that increases or improves access to health services.
- **Development of statewide delivery systems** that link aging and behavioral health services and that leverage both systems to increase reach and effectiveness of overall health services.

Administration on Aging

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

OLDER AMERICANS BEHAVIORAL HEALTH
Issue Brief 2: Alcohol Misuse and Abuse Prevention

Introduction

The Substance Abuse and Mental Health Administration (SAMHSA) and Administration on Aging (AoA) recognize the value of strong partnerships for addressing behavioral health issues among older adults. This Issue Brief is part of a larger collaboration between SAMHSA and AoA to support the planning and coordination of aging and behavioral health services for older adults in states and communities. Through this collaboration, SAMHSA is providing technical expertise and tools, particularly in the areas of suicide, anxiety, depression, alcohol and prescription drug use and misuse among older adults, and partnering with AoA to get these resources into the hands of Aging Network professionals.

Importance of the Problem

The misuse and abuse of alcohol in older adults present unique challenges for recognizing the problem and determining the most appropriate treatment interventions. Alcohol use problems in this age group often go unrecognized and, if they are recognized, are generally undertreated. Standard diagnostic criteria for abuse or dependence are difficult to apply to older adults, leading to under-identification of the problem. Older adults who are experiencing substance misuse and abuse are a growing and vulnerable population.

Over a number of years, community surveys have estimated the prevalence of problem drinking among older adults from 1 percent to 16 percent.[1,2,3,4] The rates of problems found in community surveys vary widely depending on the definitions of older adults, at-risk and problem drinking, and alcohol abuse/dependence. Estimates of alcohol problems are the highest among people seeking health care because individuals with drinking problems are more likely to seek medical care.[5] Fourteen percent of men and 3 percent of women older than age 65 engage in binge drinking.[6]

Guidelines for Alcohol Use

The National Institute of Alcohol Abuse and Alcoholism and the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocol (TIP) 26 on older adults[8] have recommended levels of alcohol consumption to minimize risky or problem drinking and to prevent alcohol-related problems.

For adults ages 60 and older the recommended limits are:

Overall consumption:

- Men: No more than 7 drinks/week, or 1 standard drink/day;
- Women: No more than 7 drinks/week, or 1 standard drink/day;

Binge drinking:

- Men: No more than 3 standard drinks on a drinking occasion;
- Women: No more than 2 standard drinks on a drinking occasion.

Older individuals should not drink any alcohol if they:

- Are taking certain prescription medications, especially psychoactive prescription medications (e.g., opioid analgesics and benzodiazepines),
- Have medical conditions that can be made worse by alcohol (e.g., diabetes, heart disease),
- Are planning to drive a car or engage in other activities requiring alertness and skill
- Are recovering from alcohol dependence, should not drink alcohol.

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Treatment of Depression in Older Adults - KIT at a Glance

Depression and Older Adults: Key Issues

for all stakeholders

Key Issues gives you an overview of important information about depression in older adults, including:

- Demographic trends
- Definitions and risk factors for depression
- Prevalence of depression
- Impact and cost of depression
- Why implementation of EBPs is important

Selecting EBPs for Treatment of Depression in Older Adults

for all stakeholders

Selecting EBPs provides information about a range of EBPs for treating depression in older adults and information about how to select EBPs. Topics include:

- What are the EBPs?
- Factors to consider in decision-making
  - Target population
  - Outcomes
  - Fit with organization
  - Training and implementation resources
- EBP categories
  - Psychotherapy interventions
  - Antidepressant medications
  - Outreach services
  - Collaborative and integrated mental and physical health care
- Case Briefs: EBP implementation strategies

EBP Implementation Guides

for each of four specific stakeholder audiences

The EBP Implementation Guides provide information for the 4 major groups of stakeholders about their roles in implementation.

- Older Adult, Family, and Caregiver Guide on Depression
  - Depression in older adults
  - How to recognize depression
  - How to access treatment
  - How to make informed choices
  - How to work with practitioners
  - Resources for older adults and their families
- Practitioners Guide for Working with Older Adults with Depression
  - Why you should care about EBPs
  - Skills for working with older adults
  - Screening, assessing and diagnosing depression
  - Selecting a treatment
  - Delivering evidence-based care
  - Evaluating care
  - Implementing EBPs
- Guide for Agency Administrators and Program Leaders
  - Why you should care about EBPs
  - Leading the implementation
  - Building momentum for change
  - Making the change
  - Managing and sustaining change
- Leadership Guide for Mental Health, Aging, and General Medical Health Authorities
  - Why you should care about EBPs
  - Why provide EBPs for older adults
  - Initiating implementation activities
  - Expanding and sustaining implementation

Evaluating Your Program

for practitioners, administrators, and members of the EBP quality assurance team

Resources and Evidence

for all stakeholders

SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

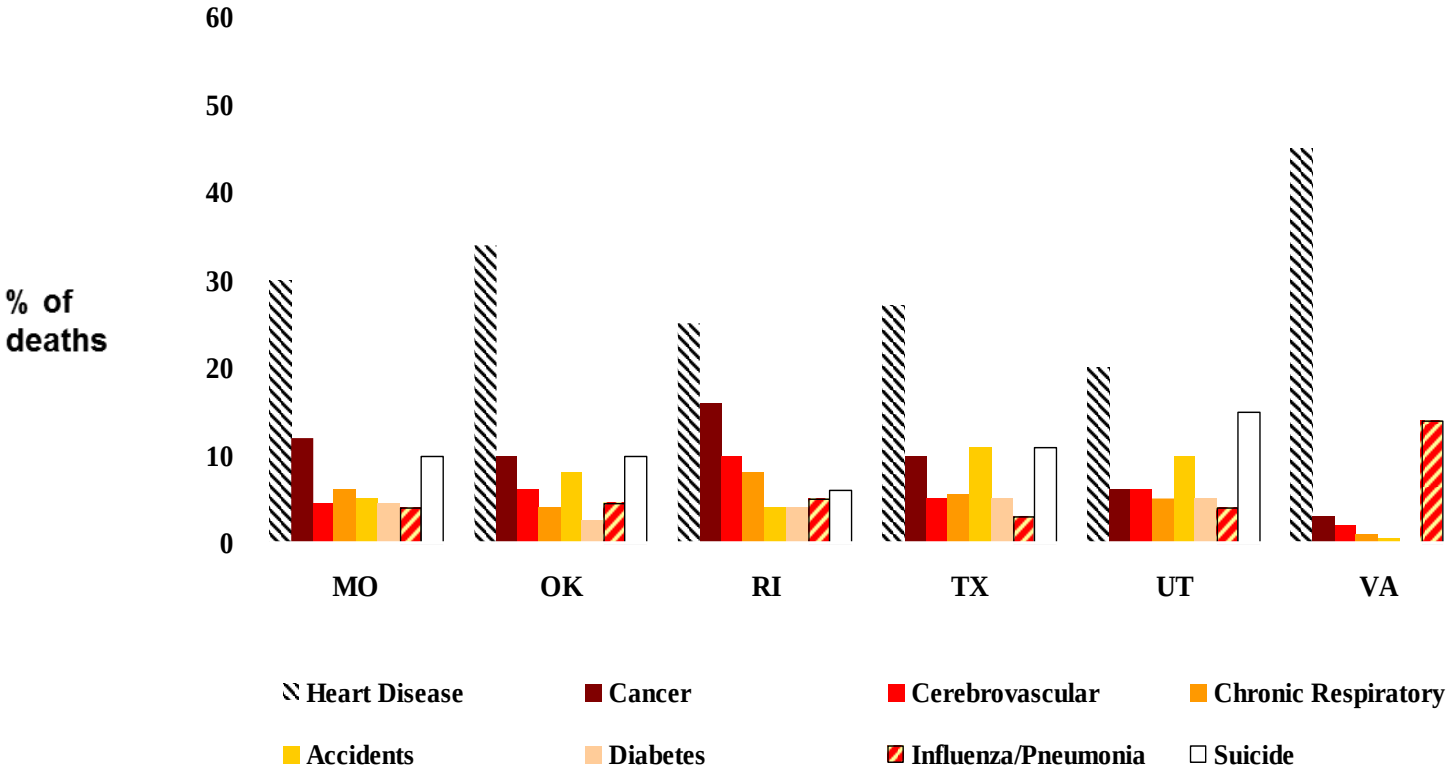
The Other Side of Integration

The Older Adult with Serious Mental Illness and Dementia in Primary Care

Mentally ill die 25 years earlier, on average

By Marilyn Elias, USA TODAY

Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early '90s when major mental disorders cut life spans by 10 to 15 years, according to a report due Monday.



Cardiovascular Disease (CVD) Risk Factors

Modifiable Risk Factors	Estimated Prevalence and Relative Risk (RR)	
	Schizophrenia	Bipolar Disorder
Obesity	45–55%, 1.5-2X RR[1]	26%[5]
Smoking	50–80%, 2-3X RR[2]	55%[6]
Diabetes	10–14%, 2X RR[3]	10%[7]
Hypertension	≥18%[4]	15%[5]
Dyslipidemia	Up to 5X RR[8]	

1. Davidson S, et al. *Aust N Z J Psychiatry*. 2001;35:196-202. 2. Allison DB, et al. *J Clin Psychiatry*. 1999; 60:215-220.
3. Dixon L, et al. *J Nerv Ment Dis*. 1999;187:496-502. 4. Herran A, et al. *Schizophr Res*. 2000;41:373-381.
5. MeElroy SL, et al. *J Clin Psychiatry*. 2002;63:207-213. 6. Ucok A, et al. Psychiatry Clin Neurosci. 2004;58:434-437.
7. Cassidy F, et al. *Am J Psychiatry*. 1999;156:1417-1420. 8. Allebeck. Schizophr Bull. 1999;15(1)81-89.

Integrated Illness Management and Recovery (IIMR) Teaching Techniques

An Emerging Evidence Based Practice

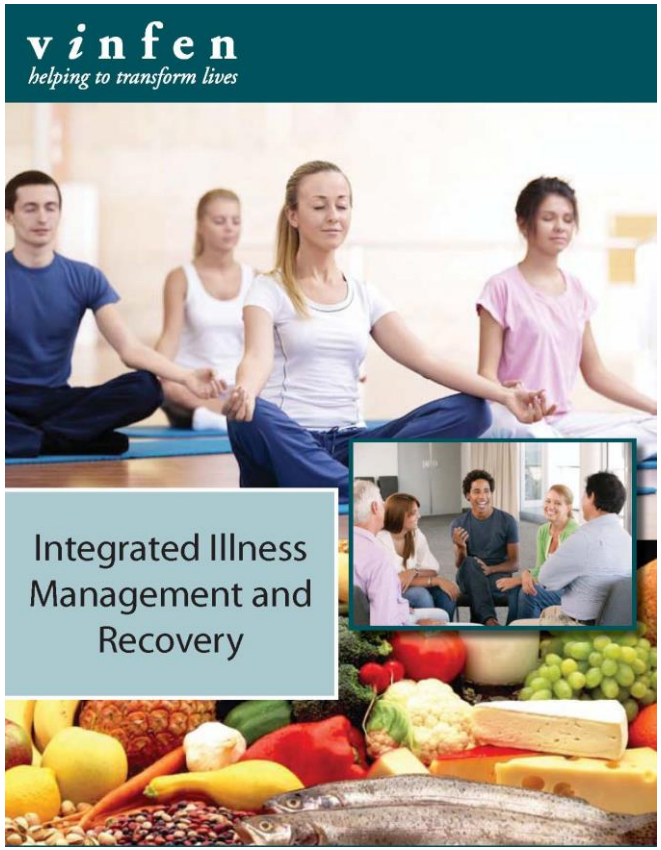
Uses

Psychoeducation

Motivational Interviewing

Skills Training

Cognitive Behavioral Therapy Techniques



Self-Management Training and Support Outcomes

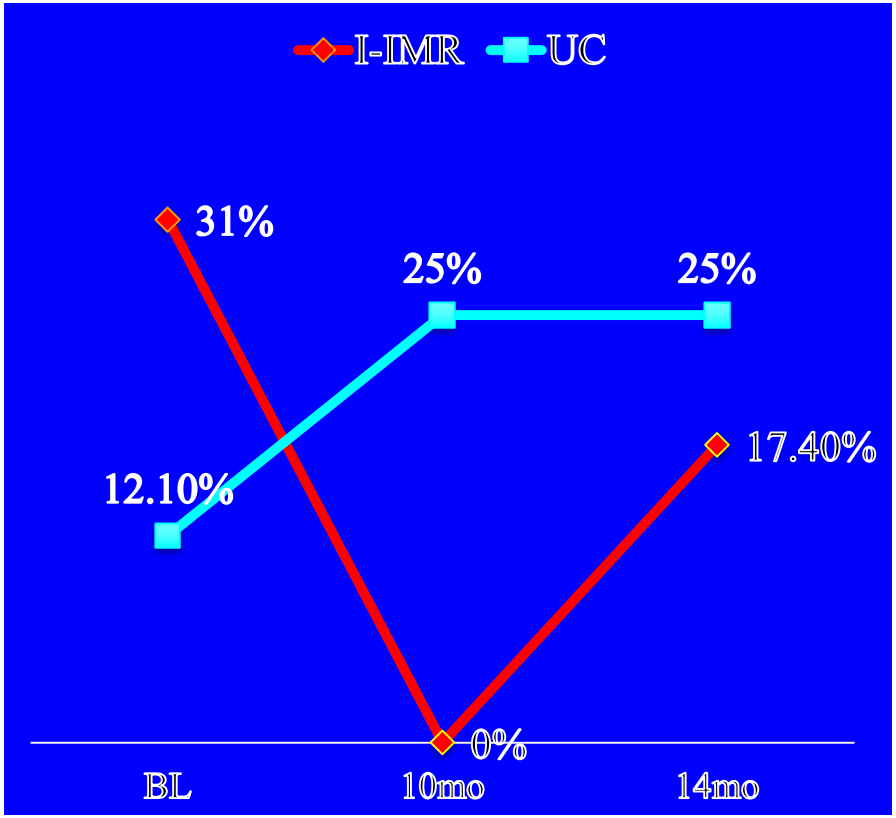
Improved Self-management

Client and provider ratings of self-management

- Knowledge of Symptoms, Meds, Coping
- Symptom Distress
- Symptoms Affecting Functioning

Improved participation in the health care encounter

Decreased hospitalizations



Challenges for Primary Care and Dementia Patients

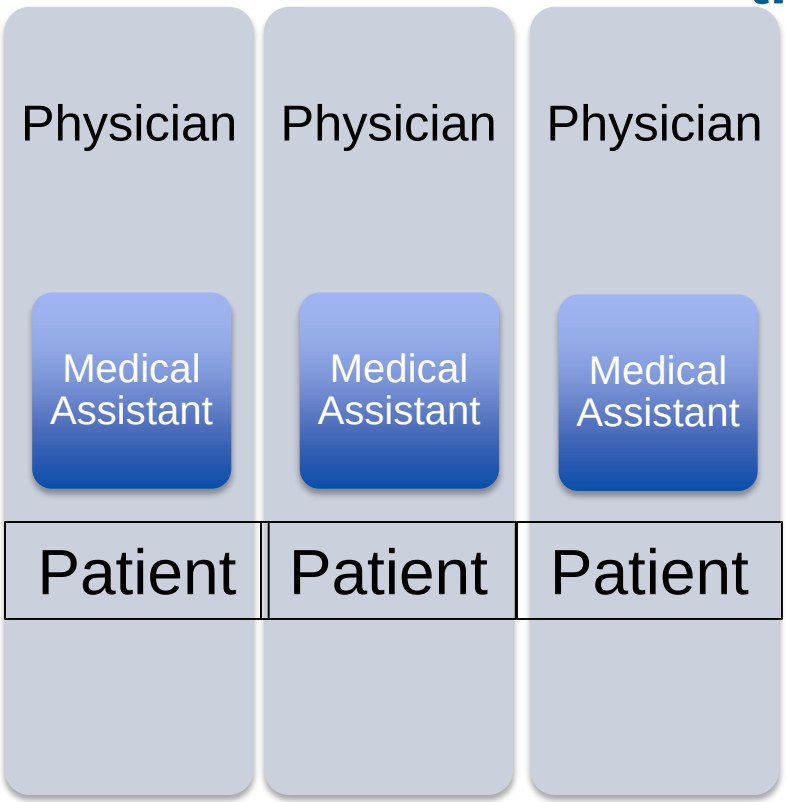
- Disclosing diagnosis and confronting difficult transitions can damage doctor-patient relationship
- Time constraints inhibit follow-up and fragment care
- Large caseload of patients
- Reactive (rather than proactive) approach
- Lack of dementia trained staff

How to get it done?

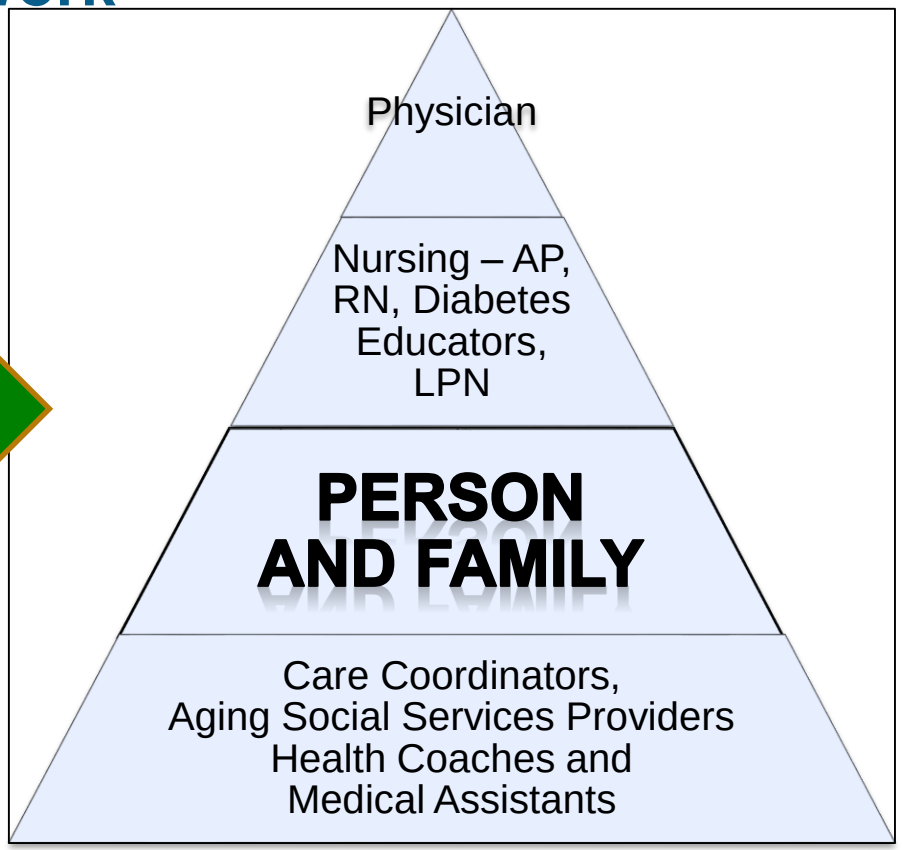
It’s About the Team!!!

Team-based care: All care team members contribute to the health of the patients by working at the top of their licensure and skill set.

HRSA Geriatric Workforce Enhancement Program
Person-Centered Integrated Geriatric Primary Care Teams that Work



Conventional Model



New Model

Dementia Care

"Team-based" based Needs Assessment and Dementia Care

"Powerful Tools for Caregivers" Training

Caregiver Support Interventions

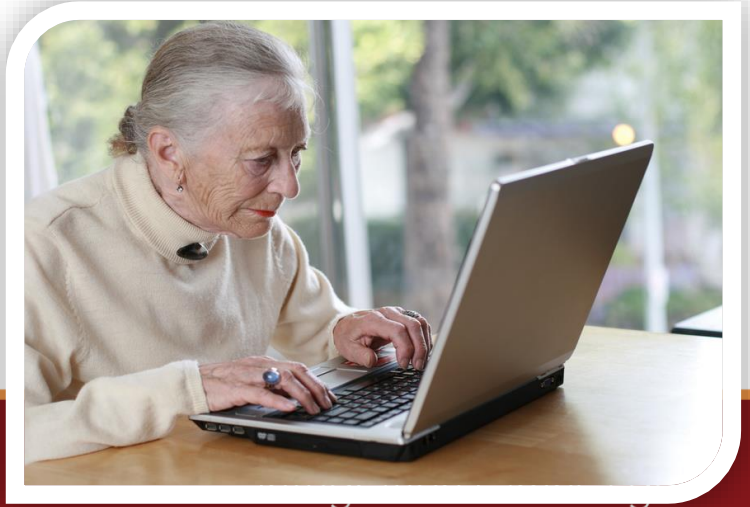
Caregiver support: Resources for Enhancing Alzheimer's Caregiver Health (REACH):

Education, problem solving, and telephone support are effective improve caregiver's mood and wellbeing and reduce morbidity for the person with dementia

Belle et al., 2006, Ann Intern Med

BUT…..What about the

Task Shifting: Combining High Touch and Technology

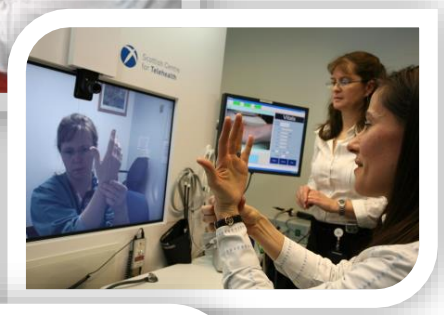


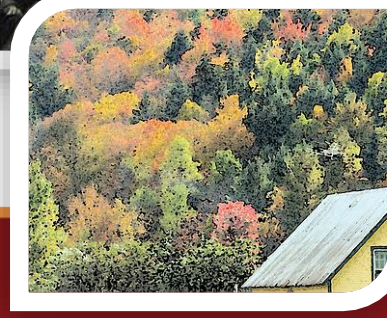

MOBILE
HEALTH

Aging Well in Community

Reverse Innovation

Smart use of people and smart use of technology





- **Community programs, education**
- **Health coaches self-management**
- **Technology** to monitor and deliver health care at home

Questions ?

CIHS Resources

Treatment of Depression in Older Adults Evidence-Based Practices (EBP) Kit

http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD

Blueprint for Change: Achieving Integrated Health Care for an Aging Population

http://www.apa.org/pi/aging/programs/integrated/integrated-healthcare-report.pdf

Integrated Health Care for an Aging Population- Fact Sheet

http://www.apa.org/pi/aging/programs/integrated/ihap-factsheet-policymakers.pdf

CIHS Resources

Differentiating among Depression, Delirium, and Dementia in Elderly Patients

http://journalofethics.ama-assn.org/2008/06/cprl1-0806.html

Talking with your Older Patient

https://www.nia.nih.gov/health/publication/talking-your-older-patient

Additional resources on older adults:

http://www.integration.samhsa.gov/integrated-care-models/older-adults

CIHS Tools and Resources

Visit www.integration.samhsa.gov or e-mail integration@thenationalcouncil.org

SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today's webinar.